RETHINKING

THE HEALING MINISTRY OF THE INDIAN CHURCH

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I

CHRISTIAN MEDICAL WORK IN INDIA

IT is not easy to give accurate statistical data on any aspect of Christian medical work in India today. The Catholic Hospitals' Association attempted a study in 1968, according to which there are 620 hospitals (hospital meaning a medical centre with 6 or more in-patient beds) and 570 dispensaries.[1]

The Christian Medical Association, the medical wing of the National Christian Council in India, in a publication issued in 1963, gave the following figures: Hospitals with ten beds or more 315; and dispensaries 117.[2] It must be noted that the Christian Medical Association of India is basically an organisation of Christian doctors; as such, this information, though covering a major part of the Christian medical work, does not cover the institutional work of the Catholic Church, the Orthodox Church and the Protestant denominations that are not members of the National Christian Council of India. There are many Christian denominations and individual groups working in various parts of the country, about which it is not possible to give any reliable statistical information. It is not even possible to estimate the number of denominations and individual groups that are working as Christian medical agencies in India.

During 1965, the Committee on Specialised Assistance to Social Projects (SASP) of the World Council of Churches conducted a survey in North-East India. At the request of National Christian Council of India, SASP again conducted a survey in 1967 to include the whole range of the Christian involvement in health in India. This work was done with

the co-operation of the Division of Overseas Ministries of the National Council of Churches in U.S.A. The purpose of these surveys was to identify problems and to get a representative view of the present situation. As a result of these studies there were several consultations and discussions. Their object was to define the principles and develop a strategy for the work. The need for Indian leadership was always emphasised at these discussions.

As a result of all these studies and consultations, we have had considerable re-thinking among the leaders of Christian medical work in India. Some of the problems that have emerged, especially those that need to be given immediate attention, are listed below :

1. Hospitals and dispensaries are mostly offering only curatively oriented service programmes to take care of the sick. But since the Government has assumed responsibility for providing health services for the people, the relevance of programmes of Christian Hospitals that are only hospital-centred and disease-oriented is by no means clear.
2. Nearly 80% of these hospitals are approaching obsolescence ; they need renovation or rebuilding, and the replacement of outworn and antique equipment.
3. Most of the staff are underpaid, and a large number of hospitals are dependent on the services of expatriate missionary personnel supported by overseas agencies. It is becoming more and more difficult to get the service of foreign personnel due to various reasons, including governmental restrictions.
4. These hospitals, though meant essentially for the poor, cannot serve the poor alone and maintain them-

selves financially. They have to cater to the rich as well, for whom better facilities in buildings, equipment and personnel are needed, obviously increasing the maintenance cost. As a result, only a relatively small proportion of the poor, who comprise the vast majority of the Indian people, can be taken care of.

5. A number of hospitals are being managed as business concerns, trying to make enough money to meet day-to-day expenses.

6. Almost all hospitals and dispensaries are operating as individual entities, all decisions being made by the Director or Superintendent, without any reference to or understanding of the work of other mission or Government hospitals, or any regard for the need of the community, or any regional planning.

7. The same pattern of individual decision-making is seen in the methods which are used to seek capital funds from overseas donating agencies. Each hospital determines its own priority needs, and submits its application with the approval of the concerned ecclesiastical authority, either to the Mission Agencies historically related to the institution or to the Division of Inter-Church Aid of the World Council of Churches. A few institutions possess direct ties and influence with foreign resources, and this often renders ineffective whatever co-ordinating action the mission or Inter-Church agencies could initiate. The priority need is determined often by the desire to increase income, consequently catering more and more to the rich. This chaotic system which benefits very few people is the antithesis of Christian stewardship.[3]

Christian medical work in India is thus facing a crisis. It becomes imperative, therefore, to ask some fundamental questions, and to re-examine the present predicament with a view to finding a new direction.

The very concept of the healing ministry of the Church needs a clearer understanding. The fact that this question has been one of the subjects for study in depth by the World Council of Churches, and has been the subject of many consultations and conferences, reveals the interest that is evinced throughout the world.[4] Can we find the movement of the Spirit of God and can we hear the voice of God in all this confusion? The demand for restating the meaning of the phrase 'Healing Ministry of the Church' is obvious. It is customary to refer to a dispensary or a hospital run in the name of a Christian denomination as standing for the healing mission of the Church. Are hospitals then the symbols of the healing ministry?

When a congregation is challenged to accept its missionary commitment, it is a common practice to appoint an evangelist in a near-by village, arrange for his support, and pretend that the challenge has been met. This chronic complacency sometimes finds expression in the establishment of a medical centre rather than the appointment of a full-time evangelist. Today quite a few Christian hospitals are established in this way. But what really is the relation of these hospitals to the life of the congregation? The old Christian hospitals were the result of the pioneering work of missionary movements. Realising the desperate need of the under-developed regions of the world, dedicated and devoted men and women offered themselves for service in such areas. As a result of their dedicated work, churches were built round hospitals. These hospitals had very small beginnings—perhaps a dispensary started on the verandha of a missionary bungalow to meet an

immediate need. At that time there may not have been a clear vision of the relation of medical work to the total mission of the Church. It merely expressed a concern and met a need. The little dispensary expands, and soon new buildings and better equipment are provided, and the centre starts to capture the attention of the public. It has now outgrown the capacity of the small, often illiterate, congregation. The Church and the congregation can no longer find a relevant place for their activities in the sophisticated and specialised programme of treatment that goes on within the walls of the modern hospital. The only part of the work in which a member of the congregation may participate is to sit on the managing committee where business is transacted, and even there he understands little of what goes on! There is a real danger of a growing sense of suspicion, jealousy and even resentment in the minds of pastors and church workers who see that the hospital staff are better paid than themselves. Members of the congregation often resent being asked to pay for their medical care. The function of the congregation in a church-related hospital now degenerates into that of recommending reductions in the bills of patients and influencing those concerned for securing jobs for relations and friends.

What is the evangelistic thrust of the medical work? At its beginning, medical work was considered as preparation for, and participation in, the spread of the Gospel. It was hoped that medical work would open closed doors, and through doors thus opened the Gospel could enter. There are many stories of the early days of how the healing that came to some member of a family became a means for the conversion of the whole family, sometimes of the whole community.

The contemporary situation is quite different. The type of medicine that is practised demands more and more

specialisation. The role of the medical personnel is distinctly different from that of evangelists or pastors. A sharp cleavage has developed today between the medical and the spiritual responsibilities, and different persons are entrusted with different responsibilities in keeping with their special qualifications. Medical work has largely become an end in itself.

All health work, both curative and public health, is essentially the responsibility of the Government. Such work is creditably carried out by many others as a secular service. Christian agencies do not have any monopoly for doing medical work, or for humanitarian activities in general. In the treatment of patients, in administering medicines, or in performing an operation, there is no special feature that can be called *Christian*. There is nothing that can be called Christian medicine. Christian hospitals have by and large lost the evangelistic thrust. Is there any justification for continuing to call them 'Christian', except as a communal label or a historical vestige?

Perhaps we should ask the question in more positive terms: What is a Christian Hospital?

Institutionalism has been a major factor which has retarded the growth of the Indian Church. The Hindu traditions in India, over centruries, have little place for institutionalised and organised religion. Religion is accepted as a movement of the spirit and is a very personal matter, an attempt to realise God for oneself.

Organisation leading to institutionalisation is part of the genius of the West, and it has done much harm to the Christian Church, by ushering in denominationalism and disunity and compromising the spirit of Christianity, which is unity. Constitutions, membership rules, committees and elections

have all played their part in shattering the unity of the Church. Medical institutions were established as a means to testify to God's Love, and to be points of contact of the Church with the world. They were to be some of the fruits of the Church, and not the Church itself. In India today the Church is buried under innumerable institutions, and mission hospitals or Christian medical activities are among these institutions.

In many cases hospitals have become the symbols of the vested interests of the Church. The Church preserves them for their prestige value. In some situations, the very existence of the Church is dependent on these hospitals, and they are defended and guarded with all the zeal of self-preservation. The Christian Church must shake off the shackles of static institutionalism if it is to continue as a movement of the spirit, a dynamic force expressing God's love and witnessing to Christ. Is it not necessary, then, to find out how best these institutions can serve the Church and the Church's Lord ?

Christian hospitals have won the admiration of millions of people ; they met a desperate need, and they rendered efficient service. Because of the rapid technological advancement, medical science today has become expensive, and mission hospitals find it difficult to compete with the free curative service given in Government hospitals. The Church has to find large sums of money if these hospitals are to continue functioning, and even then the need of the poor cannot be met. There has been substantial financial support from overseas all these years. The Church has also been receiving dedicated, qualified medical and nursing personnel from overseas for service in mission hospitals, without monetary involvement. The question arises, how long can the Church in India depend on this kind of financial support from abroad ? What is the impression that is created among

non-Christians because the Church is thus financially supported by foreign agencies? Are not churches and church-related work likely to be considered by some as pockets of 'imperialism' which are deeply resented in India today? Is it not time, then, that the churches realise this fact and take responsible action so that their meagre resources can be properly utilised on what they can maintain? It is very important for the Church to give serious thought to what its priorities should be in the future.

The revolutionary ferment that is so evident in the country demands the reappraisal of every institution of the Church in the light of changing situations. However greatly respected an institution may be, it cannot afford to refuse to move with the times. Is it possible for the Christian medical work to study these changing situations, and redefine its role and mission?

Missionary work in India has been noted for its pioneering quality. Today the era of the foreign missionary is gone, and churches are increasingly becoming indigenous. The Church will have to seek new ways of finding its moorings in the changing world. There is every reason to rejoice in the fact that, at least in a small measure, the Christian medical missionary work has stimulated the Government to take some responsibility in the development of medical care. It is essential that the Church plans its future medical work, giving due consideration to national programme and planning, and with an awareness of the new pioneering role it has to assume now in the field of medical work.

Indigenous forms of medicine existed in India from very ancient times. In one of the four Vedas, which form the basic scriptures of Hinduism, there is an elaborate treatise on the symptoms of diseases, their diagnosis, and prescrip-

tions for their treatment. The treatment consisted in strict dietary restrictions, administering by mouth concoctions made out of portions of plants, and the application of oils and other ingredients locally available. There are also instructions regarding massages, baths, rituals and penance. The Brahmins were the custodians of the Vedas and they alone had the right to practise this system of medicine. It was therefore difficult for the poorer classes to benefit from this system.

Animism of one kind or another was, and is, widely practised in the villages of India. To the people of the village any phenomenon that is not within their understanding is caused by a spirit or some supernatural power. It is believed that illnesses are caused by the revolt of elements over which man has no control. Attempts are therefore made to placate the spirits that have been offended. This has given rise to an elaborate system of sacrifices and rituals. Behind the whole process is the belief that man has to keep peace and be in harmony with the powers of nature, and that a break in this relationship can have serious consequences. The village pujari wields immense influence, especially in times of sickness and death. It is into this situation that the early pioneering Christian missionaries brought scientific medicine. Christian medical work introduced a new spiritual power as well, disturbing the hold of the old belief.

As a result of evangelical revivals in the West, both in the Roman Catholic and Protestant churches, considerable enthusiasm was generated for the missionary enterprise. Poverty, ignorance and superstition in under-developed countries have often been a powerful challenge to the people of affluent areas. Though the theological basis of the missionary endeavours might have not been very clearly defined, there was considerable personal and group involve-

ment in the work. There was a fervour, a sense of urgency and a preparedness for self-sacrifice among these people who contributed richly to the glorious annals of mission history. The support of the churches as a whole came much later. In fact, some of the churches positively discouraged such enthusiasm to begin with.

Medical work was not adequately recognised in the early years as part of the 'apostolic ministry' of the Church. It started in many cases as the result of a sudden decision to meet an obvious need. The very low standard of living and consequent ill-health were an appalling reality which the missionaries had to face. Their genuine compassion for the sick and suffering sometimes led to conversions to Christianity. The medical missionaries found that if they were not able to meet man in his need, especially in sickness, their message had very little meaning. They learned soon, that sickness, in the minds of many Indians, was to a great extent associated with beliefs in gods and goddesses. The whole method of evangelism needed a new approach if the Gospel was to be understood. Thus medical work became a necessity. Though the motive was only to demonstrate compassion or to alleviate suffering, the resultant preparation for the Gospel was obvious. This was also an obvious attraction for the missionary.

At about the same period, scientifically trained British medical men were brought to India by the East India Company to take care of their sick personnel. As the Company expanded and became more of a political force, it needed more medical men from England, and gradually, when India became a part of the British Empire, public hospitals were established. Scientific medicine thus became available to the public. As the demand for scientifically trained personnel increased, for public hospitals as well as for

military personnel, medical education was introduced in India—first in Calcutta, Madras and Bombay. This was the beginning of university involvement in medical education. The Government expanded its medical work by developing more and more hospitals. Some of the Protectorate States also began to have medical service departments in the Governments. The need for public health measures became apparent at a later stage, and a separate Department of Public Health was instituted. With the advent of independence, the Government accepted that the right to medical aid constituted one of the fundamental rights of all citizens. Thus the Government of India and various State Governments rapidly expanded the existing facilities. The number of medical colleges increased from 18 in 1947 to 94 in 1969, and the annual number of graduates in medicine increased from 2,000 to 12,000. Primary Health Centres in various Developmental Blocks were introduced during the phased Five Year Plans of the Government.

How did the traditionally oriented, illiterate Indian accept the western or scientific medicine? As we saw, sickness was regarded as the manifestation of the displeasure of supernatural forces and atonement was made possible through the medium of pujaris, the rituals performed being the important thing. In this set-up it was easy to substitute the new scientifically trained doctor for the pujari, and his medicine for the quasi-magical material medium of the rituals. It was not uncommon for doctors to be considered as objects of reverence, and for patients to fall prostrate before them in worship. Modern medicine also has its times and specifications, and all this fitted beautifully into the old, superstitous pattern.

It is often observed that patients, after getting themselves cured in a hospital, go to shrines or temples to confess their

sins and guilt and establish peace with God. The scientific medical man does not usually appreciate these basic spiritual values which are inherent in the Indian cultural pattern and come to the fore during times of sickness. This often renders him unresponsive to the demands of a person for total healing.

Christian hospitals are understandably popular. Part of the reason for this popularity is the general lack of competition. The Government is not able to develop adequate and comparable health programmes, especially in remote areas. Credit must also go to the Christian hospitals where we have had real concern and compassion for the sick. In the early days, treatment was generally free, as the whole programme was supported by funds from overseas Mission Boards. Of late, however, the whole situation has changed. Mission hospitals which did not have administrative control by or financial support from the local church and had direct relationships with foreign mission boards, are being handed over to local churches. These churches have neither the financial resources nor the technical personnel to take over additional responsibilities, but, nevertheless, they are eager to obtain and control the accompanying assets and enjoy the prestige and the power.

Many of the mission hospitals are no longer meeting an urgent need. They remain as symbols of denominational self-importance. The Church is in a dilemma. Unless the Church can find new ways to meet the needs of the community and help in its development, with the aid of these mission hospitals, the very existence of the hospitals may well become a burden to the Church.

What was pioneeering at one time has become routine now. How can the Church meet the need of the total man? How can we have new dimensions in the thinking, planning and

doing of Christian medical work? Will the Indian Church have the courage, wisdom, power and faith to make radical changes in its thinking on, and its structuring of, medical work?

Those involved in church-related medical work will have to accept the responsibility and demonstrate the method of meeting the health needs of the country. They are already playing a significant rôle in the health care of the people. Fourteen per cent of the beds available for the sick in the country are in mission hospitals. Some of these hospitals are among the best in the country, commanding great respect and enjoying great popularity. The churches have also taken a due share in the training of all categories of medical, nursing and paramedical personnel. A good deal of experimentation has been attempted in collaborating with the Government, from the primary health centre level to that of the highly advanced medical colleges. The experience gained so far will no doubt help us in our future planning. But we must change our outlook and our method, and we must change them drastically. Christian medical work cannot afford to ignore its theological basis—that total health or wholeness is salvation, which is possible only through Christ. The Church must pioneer once again. It cannot merely follow the methods adopted in other countries, especially in countries with totally different cultural and economic backgrounds.

II

THE FERMENT IN INDIAN SOCIETY

INDIA has completed over two decades as an independent nation. The present period in India's history is one of unparalleled unsettlement. It is the duty of any one who is concerned with the mission of the Church to interpret and evaluate the changes that are taking place in every sphere of our life. Only thus can we make the message of the Church relevant and challenging. Until the Church comes to participate actively in this ferment, she will not and cannot be recognised as a force in the nation's life.

The concept of secularism as defined by Pandit Nehru and accepted by the nation involves (1) the separation of religion from the State ; (2) a social pattern with a uniform law, and with no religious impositions or sanctions, and (3) fundamental rights for all, irrespective of the religious denominations to which people belong.[5] The Government of India does not identify itself with any particular religious group, but provides freedom for all religions to be professed, practised and propagated.[6] It is interesting to examine the impact of this concept of secularism on the ordinary man's life. It has meant for him a liberation from the thraldom of beliefs and sociological patterns which for centuries had been considered unalterable and even sacred.

India is a miserably poor country, in spite of her wealth of resources in land, minerals, manpower and opportunities for development. The great majority of the population live off the land and depend for their existence on nature's elements, rain and sunshine. They believe that these elements are controlled by supernatural forces, and a sub-

stantial portion of their time and meagre resources is spent on appeasing these unpredictable powers. Today, however, the situation is changing. People have begun to realise that at least some of the modern technological agricultural advances are within their reach. They now have greater control over the produce of their land. This has its effect on the economic viability of their existence, but, more than that, the new-found freedom and sense of mastery over nature have revolutionised their outlook on life.

There is, consequently, a recognition of human creativity. As we have seen, in the past the activity of man was curbed and curtailed by social and religious sanctions. He was ruled by the iron hand of custom and tradition. Now he is emerging from his age-old prisons and venturing into once-forbidden areas.

Protest, sometimes violent, against religion and authority in general, is very much in evidence, and this has to be viewed from our new perspective. In the past the thinking of the Indian people was largely fatalistic. It was characterised by an unquestioning acceptance of the inevitability of the *status quo*. While famine and suffering had ushered in revolutions in other countries, India, with her starving millions, accepted things as they were, and lived with a certain philosophic resignation. Now we are being drawn out of this age-old lethargy. We are no longer satisfied with the hand-to-mouth existence to which we were accustomed till recent years. We want change, immediately and rapidly. The dynamism of this ferment challenges all set patterns and preconceived notions, in spite of their religious and historic sanctity.

Along with the new feeling of freedom, we also experience a sense of fear. It is due to the uncertainty as to whether this new power is for the benefit or the detriment of man.

The question is, do we have sufficient moral courage and wisdom to control and harness the power in a way that is truly beneficial to us ?

The warnings of the great saints and seers of the past against materialism echo and re-echo in our ears today. The genius of India has found expression in every century in men like Buddha, Gandhiji and Vinobhaji. They have all questioned the wisdom of seeking happiness in the abundance of material things.

The urge for freedom is felt among the rank and file of our population. The old foundations of society are being cast aside as inadequate and unacceptable in the new world. We seek new foundations for a new society. For centuries Indian society was based on rigid custom. The old had the authority to decide for the young—on what professions should be chosen, what kind of education should be given, and who should be chosen as life partners. Their decisions were made on the basis of status, caste and creed, whose roots extended deeply into centuries of tradition which provided the cultural ethos. Anyone attempting to break these barriers had to face innumerable problems, including social ostracism. Today the young increasingly disregard these traditional barriers. The political revolution has set the pace for revolution in other spheres.

For instance we have 'the revolution of rising expectations.' In the past, poverty and simplicity were accepted, and often embraced as the spiritual way. Kings and sages who forsook the world were our heroes. There was an almost romantic love of poverty. Today, however, man is aware of new horizons. Technology which provides a higher standard of living in other countries has cast its spell on the Indian villager also. He no longer accepts poverty as

inevitable. On the other hand he sees no limits to the possibilities of what the new world can provide. Discontent with the present conditions of existence is rife, and this provides an atmosphere conducive to revolution.

The accepted relationship between father and son and between man and wife is being questioned. There is universal demand for a more equitable distribution of opportunities. The woman does not want to be confined to the domestic sphere alone. She vies with man in all walks of life. Trades and professions are no more accepted as the prerogative of any one caste. It is this new-found freedom which breaks the old relationship between people. This freedom has also occasionally affected the relationship between ethnic groups. Groupings which in the past were based on caste, class or custom exercised a strong influence on the individual and on society when man's world was limited only to his kindred and to the village in which his ancestors were born, worked and died.

The emergence of new methods of communication and transport—the telephone, radio and loud-speaker, increased facilities in transportation—has also contributed to the new climate. The average Indian is learning that his family is not confined to his own village or caste, but extends to the farthest corner of his own country, and even to other countries of the world. Along with the excitement, there is the feeling of apprehension. What are the implications of his widened horizon ? What might be demanded of him in the future ?

The ordinary citizen is learning fast the fundamentals of democracy. He is becoming increasingly aware of his right and responsibility to share in the governing of his own country. He is becoming assertive and his aspirations and demands are made known through parties and unions.

The ferment of change is also apparent in the sphere of religions. The many attempts to liberate large areas of human behaviour from the controlling influence of religion suggest that the day of ancient religions is over. In reality, this is far from the truth. Hinduism is infinitely accommodative and can cope with new tensions. Through the centuries, Hinduism, for the masses, was a matter of rituals, traditions and customs. They paid homage to many gods and goddesses and expected benevolence in return. Religion had thus become a part of Indian culture, though we should recognise that rituals and traditions have become dogmas in the hands of religious teachers. Hinduism, as propounded by the philosophers who take their stand in the Vedas and the Upanishads, is quite a different affair. They proclaim that there are not many gods and goddesses, but only one God. The various incarnations only depict the many facets of the Universal God, and idols are merely to help us in our state of ignorance. They readily accept that there is no power in the wooden, golden or stone images of the deities, and that they are a concession to our weakness. It was into this climate that Christian teachings came through the effort of missionaries from the western world. They brought Christianity in the garb of modern civilisation and culture. The impact of Christian teaching on this ancient religion has added to the ferment.

There are two directions in which the new thinking is unfolding. In the first place, the ancient religions have come to resent defections from their ranks. There is strong feeling today against conversion. The charge against Christianity is that it is a foreign religion. The challenge has been taken up by Indian Christian leaders, and there is much talk of indigenisation.

Secondly, there is the attempt to reform themselves. Paradoxically enough, they want to free themselves from some

aspects of the national cultural moorings. To speak of Hinduism as anything other than Indian is difficult. The thinking Hindu knows that the way out is that of the assumption of universalism. This makes it necessary to make a clear distinction between Hinduism and Indian culture. Thus the defenders of Hinduism are trying to absorb as much of Christianity as possible into their own religion, which obviates the need for conversion to Christianity. They are also concerned about turning Hinduism into a dynamic world force, by setting it free from what is Indian in a restricted sense. Propaganda and evangelistic programmes are no more the monopoly of Christianity. In addition to the general defensive approach, there is also a revitalisation from within the Hindu faith. This revival in modern Hindu movement has gathered much momentum during the past decades by the powerful writings of acknowledged national leaders. Philosophers and social thinkers are attempting an authentic interpretation of man in society, still taking their stand within the Vedas and the Upanishads. This struggle is of extreme importance to the Christian; he must study it with sympathy and sensitiveness.

The term 'Democratic Socialism' is frequently used in India. It is often taken as a special concept peculiar to Indian society. 'Socialism' of course appears differently to different people, but in India the emphasis is placed on the ideology and not on the methodology. 'Democratic Socialism' implies a particular way of life which the masses of India have come to regard as holding the greatest promises for them. Through it they hope to achieve the maximum emancipation and acquire the maximum meaning for their lives.

Centuries-old cultural heritage has conditioned the pattern of life in India. The keynote of her culture was to give the highest value to spiritual life and the search for Truth. With-

in limits, this cultural heritage did enjoin respect for human personality. There were elements in our cultural heritage which resisted change and made us backward-looking. This is often reflected in our attitude to things and our way of life. The argument, 'It was good for my fathers, so it is good enough for me too', is heard very frequently. The eagerness to defend the *status quo*, along with the desire to hold on to fatalistic concepts, makes progress slow and difficult.

The forces of nationalism have awakened the masses. Less than a hundred years ago, a lecture based on the biblical text 'Except a grain of wheat falleth to the ground and dieth, it remaineth by itself,' given to a group of undergraduates by a retired British Army Officer at the Calcutta University, led to the formation of the Indian National Congress. The political movement for national liberation, led by the Congress, found under the leadership of Mahatma Gandhi a broad-based mass support. To awaken the nation out of centuries of contented acceptance of foreign domination and to prepare the people for sublime acts of self-sacrifice were not easy tasks. The new creative spirit of the waking nation moved from shore to shore, from north to south, resulting also for the first time in its history, in an integration undreamt of in the past. The leading note of this movement was an awareness of the spiritual values of life, the love for one's country, love for that which is Indian in clothes, in customs, in behaviour, and the desire to relinquish that which is foreign. Thus today, national traditions and culture hold an important place in the thinking of Indians. Indians want India to remain Indian and not slavishly copy the cultural patterns of the affluent countries. Both as a mystic and a spiritual leader and as a statesman, Gandhiji won the admiration of the masses. He was afraid of India's losing her spiritual values through rapid industrialisation. He saw with clarity that industrialisation, though it solves

the acute problems of poverty with great speed, brings in its wake evil forces which are dehumanising and will create tensions. Though he knew that his theory of slow industrialisation might not yield quick results, he could not bring himself to advocate a way which, he knew, would be disastrous to cultural values. The village-centred Gram Swaraj with self-sufficient units and controlled needs appealed to him. In the Panchayat Raj India planned to retain at least a certain measure of the Gandhian concept of Gram Swaraj.

Nehru succeeded Gandhi on the national scene in more than one sense, but he never shared Gandhiji's outlook on society or economics. He knew that in order to solve the problems of the millions in India, we should resort to rapid industrialisation and increased production. He applied himself to national planning on a large scale. He wanted to achieve better standards of living. The concept of democratic socialism in India owes more to Nehru than to any other single individual. But he was not able to stress the importance of spiritual values in the way Gandhiji did.

Communism, of both the Chinese and the Russian varieties, also has its influence on a section of our people. It has helped to direct the minds of the people to the realities of hunger, of nakedness and ignorance. The Communists have been teaching the masses that revolution and the overthrow of power will alone ensure development, and that delay will result in increased deprivations. They too have contributed to a sense of self-identity among the workers and peasants. Collective bargaining and organised 'fights for rights' have been accepted as part of the normal procedure. But short spells of Communist governments in a few states have created grave doubts in the minds of many. Though the ultimate object of the Communist Party is the emancipation of the working classes, the thinking

public is beginning to wonder whether the working classes are not being used as pawns in the game of power politics and self-seeking.

To the ordinary man, this ferment forms the climate in which he may make his demand for a better standard of living, a part in the structure of the economic life, the right to contribute towards national development, and a share in the resources of the nation. The spiritual values of our cultural heritage, which had been the keynote of Gandhi-ji's teaching, however, are fast disappearing.

Advancement of technology, freedom from want and poverty, rise in living standards, better educational opportunities, improved health conditions and sophistication in general, have all tempted millions in developed countries to drift from spiritual foundations and lose sight of human values. Is India following the same perilous road, and losing its old heritage? The offer of abundant life through the Universal Christ is what the Indian Church has to proclaim to all. In this proclamation the Healing Ministry must play a significant rôle.

III

THEOLOGICAL FOUNDATIONS

A significant part of the public ministry of Christ is given to healing work. Twenty-six cases of individual healing and ten cases of healing in groups are recorded in the Gospels. Taking into account the cultural, sociological and political ferment among the Jews at that time, these acts of Christ seem to have marked a departure from the traditions of the judges and prophets. The prophets communicated their message with symbols and signs of a different kind. Healing itself was not a popular profession in Jewish tradition. The Jews tended to believe that all suffering was due to the sin either of the individual or of the community. Sickness, resulting in suffering, was due to one's disobedience and ungodly life. It is not possible to alleviate suffering without dealing with its cause, and the cause, for the Jews, consisted in sin. Since man is incapable of forgiving sin, there was nothing that could be done to reduce human suffering. Our Lord did not raise any question on the basic logic of this argument, but He taught that it is the will of the Heavenly Father that man should have abundant life. He demonstrated that He has the right to forgive sins. The case of the paralytic man is an illustration of this. Jesus told the patient that his sins were forgiven. To the Jewish listeners, this was unpardonable blasphemy, because Jesus was doing what God alone could do. Jesus proved His authority by asking the patient to get up and walk. Thus in that case the healing was a proof of the fact that He could forgive sins, for which He had come. The answer given to the disciples of John the Baptist also explains the purpose of His coming. The deaf hear, the dumb speak, the blind see and the kingdom of God is being

ushered in. Healing, for Christ, meant the restoration of the whole man, his total rehabilitation. God wills for him fullness of life, and this means health of body and health of mind and spirit. These cannot be separated, and Jesus' emphasis is on the total health of the individual and of the community.

The materialistic or negative definition of health—such as absence of disease, or the ability of the body to function normally—cannot adequately express the Christian concept. Even sociological definitions which stress the ability of the organism to adapt itself to the constantly changing external and internal environment and the relation of love and work—in the terms of Freud—fall short of the Christian understanding. Health is given the highest importance among human values by many in the developed countries; yet the word 'health' is usually used in a narrow sense, and the ideal of total health as abundant life is seldom appreciated. In the Christian concept, the healing of physical sickness is only a part of the healing task whereby man is enabled to participate in the abundant life in Christ for the fulfilment of God's purposes in the world.

It is important to consider the Healing Ministry in the true Christian perspective. Jesus was not concerned about mere healing of the sick; his work cannot be described as health service in our normal sense. His healing work is to be understood as a symbol, a demonstration and 'an arrabon', the beginning of greater healing to follow.

His concern was for the community rather than for the individual alone. The prophets of the Jews addressed the whole people—'Hear O Israel!' They were not speaking to individuals, but to the whole nation of Israel as one. Each individual was only part of the whole, sharing the destinies and the sufferings of the nation.

In the story of Achan, when due to his rapacity he tried to cheat God, the punishment fell upon the whole nation. Naaman asked for a bit of earth that he might symbolically join with the people of Israel in worship in a distant land. This concept of corporate personality is central to Old Testament teaching. In the New Testament, the same idea is brought up in the New Israel, the Koinonia, the Community.

The representative element in the healing miracles of Christ is significant. They are 'on behalf of' or 'instead of'. Both these ideas are inherent in its meaning, yet the Gospel concept is more than either, and more than both. 'What you have done to these little ones, you have done unto Me' can be understood only if it is appreciated that Christ identifies Himself with all men.

Christ was God incarnate; he was also the representative Man. He was healing not just the physical sickness of the individual person, but giving more than positive health for the whole man, granting abundant life and salvation. Man can participate in his representative nature, even in his death. Paul says, 'I am crucified with Christ.' The participation is not only in his death, but also in His whole life and ministry. 'Do this in remembrance of Me' is a demand to remember his death, and also the whole of his Ministry[7]. Christ claimed it explicitly in His sayings[8].

The representative nature of Christ has a four-fold aspect in every situation of human service and witness. He is the Sick, the Prisoner, the Child, and the Stranger. Further He becomes the Giver of the cup of water, and of the clothes, and He becomes the Visitor. He is the one who preaches the Gospel, and He is also present in those who receive the

Gospel. The title 'Son of Man' that Jesus used, incorporates Isaiah's picture of the suffering servant, and symbolises His identity with the community which would have to suffer for the world. It is a corporate effective sign of the fact that mankind as a whole has started the process of dealing with sickness and suffering decisively and victoriously, to restore total health to fellowmen, equipping them for the abundant life of salvation.

The sick men were representative of the community and the selective nature of Jesus' healing work exemplifies this concept. What was His motive in the selection of those sick people? Jesus had compassion on everyone, but He avoided the pressure exerted on Him to heal for the sake of healing alone. He healed the mother-in-law of Simon[9] and He raised from death the brother of Martha and Mary.[10] He chose the deaf that could not hear the Word of God, the blind that could not see His Glory, the dumb that could not utter His Name, the lame that could not walk in His Path. In dealing with these defects and limitations in individuals, He is dealing symbolically with the needs of the community as a whole.[11] There is a gradual extension of the community; from the synagogue[12] to a Jewish house[13], and Jewish city[14], reaching out for an outcaste[15], to the great step of meeting the whole world.[16] The motive in all cases was to establish that the works of God should be made manifest in Him.[17] The fallen state of man, or the lost sheep, presented itself to Him in sickness and suffering, and He dealt with it by restoring it to total health to usher in the new era of human freedom and salvation.

Christ presents Himself as the humanity that heals the sick and suffering, the fallen and lost, while the witnessing crowd represents the world. The faith of the witnesses was necessary as a prerequisite for the effective carrying out of

the Lord's ministry of healing, and where there was no faith, He did not heal. The importance of the community's participation was thereby made evident. Faith in the New Testament is not an intellectual dogma. It is the insight to discern and recognise Jesus Christ as Lord and Saviour. Healing acts provided an opportunity to demonstrate faith. Faith is eschatalogical, it is advance payment for what is yet to be accomplished when His Kingdom is finally established. It is also theophany; it is a revelation of the finger of God that has stretched out to touch the world of sickness, to produce total wholeness. When the people who witnessed the healing had faith, that faith made it possible for them to have a glimpse of the Glory of God, almost as if a veil were removed for a moment. The witnesses had the option either to have faith and respond in obedience to His call, or to reject Him and scheme with the community for His crucifixion.[18] It is important to appreciate the representative character of the Healing Ministry of Christ, if we are to attempt a proper re-evaluation of the Church's Ministry of healing.

The experience of the early Church in its attempt to obey the command of Christ 'Go, Preach and Heal' demonstrates another aspect of the ministry of healing.

The Risen Christ, being present in the Church through the gift of the Holy Spirit at Pentecost, renews this ministry within the Church in a special way. St. Paul's emphasis on the Life 'in Christ' and the proclamation by the early apostles that Christ is Lord and Master suggest that He is present in every man as Saviour. Those who have accepted or recognised Him realise His Lordship, but to all, whether they realise it or not, He is Lord. This disclosure of His Lordship is total healing. The lame man in Acts[19] points to the inadequate attention given by the world to deal with

the consequence of sin and suffering. He was brought to the temple gate for begging—a compromise or a second best. Peter and John representing the Christian community, recognised the deeper need of the man, offered the right hand of fellowship, identified themselves with his sufferings and healed him. The occasion becomes a crisis of faith both for the lame man who received healing and for the crowd in the temple. Peter explained the significance. They who discerned the presence of Christ believed in Him.[20]

The Epistles of Paul (especially I Corinthians 12) mentions healing as one of the gifts of the Spirit, given for the building up of the Church. The work of the Church is a total ministry to the whole world—of preaching, of healing, and of bringing more and more of the world's principalities and powers within the acknowledged Lordship of Christ.

The following points emerge from a study of the meaning of the command of Christ ' Go and Heal ' :

1. The mandate to heal is for the whole Church. The responsibility of the Church is to proclaim that Christ is the Lord of all and that He is present in a special way in the Church. This special presence is for the sake of the world. It is for healing sickness is a wider sense, and for bringing the world under the conscious and visible control of His mighty power.

2. The specialised ministry of medical aid is to be viewed within the total ministry of the Church.

3. The sick person represents the community and his healing has to be viewed in that context, as an opportunity for the congregation to manifest God's love and concern.

4. Community participation and involvement is essential to effect total healing for abundant life.

IV

ROAD TO 'DEVELOPMENT'

'DEVELOPMENT' is a word that has caught the imagination of our generation. An awareness of the total needs of the community and the willing acceptance of responsibility by the community to meet those needs are essential elements in a constructive approach to the problem of development. Extreme poverty can paralyse the sensitivity of the community and render it difficult for the community to recognise its own needs. The community is unable to see beyond its economic situation or to conceive of ways to overcome it, and it is practically impossible to consider any facet of development without involving economic considerations.

In India, the root cause of many illnesses is poverty. Here, as elsewhere, there is an intimate relationship between health and economic development. There is no doubt that the most productive investment for economic growth consists in providing adequate health for the community. The development of the health of the community will depend on the community's ability to recognise its health needs and on its preparedness to meet those needs. Unfortunately, there is often a mistaken sense of complacency, and a tendency among the poorer classes to blame the well-to-do for their poverty, illiteracy and all other underdeveloped conditions. People expect to be provided with everything they need, and are unwilling to put in any real effort on their own part.

The indiscriminate flow of foreign funds has not contributed to the growth of creativity, dynamism and self-reliance. Christian medical work in the mission hospitals has been no exception to this general state of affairs, and this adds urgency to the search for new foundations.

The word 'health' may be understood differently by many, and a brief explanation of what is meant here may not be out of place. Historically, health means, 'absence of disease or disability'. Measures to prevent diseases, at the individual and the community level, have become a part of health services all over the world. To this has been added the concept of positive health, of such a state that promotes good health. In addition, it is increasingly appreciated that the mental well-being of the individual also is essential for health. In the Christian concept, health includes not only the physical and mental well-being, but also spiritual wholeness. The corporate health of the community, therefore, is dependent on the health of individuals. Because 80% of India's population live in rural areas, the term 'preventive and social medicine' or 'community health' often meant prevention of disease, or dealing with the social pathology at the level of the rural community. It is useful to emphasise that the word community includes both rural and urban. 'Comprehensive health' is another term much used in medical literature, which may be given varying interpretations. However, comprehensive health denotes a combination of curative health service in hospitals and public health measures to prevent diseases, with some emphasis on positive health. The phrase 'integrated health care' used in this study is intended to comprise all facets of health leading to the wholeness of man.

Progress in the development of the health of a community demands its ability to recognise its health needs and assume responsibility to meet those needs. When a person becomes sick, he and his relatives are naturally anxious to have him cured, and they seek the help of a doctor. The community does appreciate the need for hospitals to provide curative service, but it seldom recognises the many factors which bring about sickness in the first place. It should be

the purpose of Christian medical work to educate the community to become aware of its basic needs and to participate with it in its responsibility to take effective steps to meet those needs. This means that Christian Medical work will not only be involved in curative and public health measures alone, but also in many other aspects of the development of the community, leading to total health. Development of the whole personality or the total health of the community can alone be considered as the goal of ' integrated health care ', and Christian medical work will have to be directed towards this objective. Mission hospitals must become servants of the community, and not mere health repair workshops. Missions are no longer run by Christians alone. Hospitals run by Ramakrishna Mission and other philanthropic bodies have reproduced effectively the care and concern the Christian hospitals have demonstrated.

In marking out a new road to development, the churches have to take the following factors into serious consideration :

(*a*) the revolutionary ferment in the country,

(*b*) the Government's concern for running health services for people,

(*c*) the entry of many more international and other voluntary agencies into the area of medical services,

(*d*) the changes within the administrative structure of churches and mission hospitals,

(*e*) the financial difficulties most of the hospitals face because of (i) the rising cost of medical care, and (ii) the declining financial support from overseas.

Christian medical work must discover a new rôle, which it should assume within the context of national develop-

ment. The churches will have to be responsive, and take new directions within the mandate of Christ which asks us to ' Go and Heal '.

1. A New Relationship

Since our faith has to do with this world, which is real, healing means a total restoration of the human personality, within a healing and healthy community. The gulf between physical healing and spiritual well-being must vanish, and the Church should get out of its institutional structures in order to establish a new partnership with medical teams, through affirming the identity of aims and purposes. The kind of institutionalism which prevents this bold breakthrough and expansion in new directions should give place to a genuine acknowledgement of the compelling concern for the human need and its demands.

Historically, the development of most of the churches and of their mission hospitals took place through almost completely separate channels. The overseas mission boards sponsored and controlled the development of mission hospitals. There was no administrative or financial relationship to the local churches which were supported by similar mission organisations abroad. In recent years, the foreign boards have been trying to transfer the responsibility for all of their work to the local churches. The churches are often in great difficulty because they have neither the personnel and financial resources nor the technical knowledge needed to manage these hospitals. Medical committees and boards were set up by the churches with the hope that such organisations would be able to administer these hospitals. However, since medical work is a specialised field, it is necessary to give adequate opportunity to the medical team to take up responsible leadership. The doctor in charge of the mission hospital,

who is the team leader of the integrated health care programme, should have the responsibility for all aspects of the work, including its finances. He should have the freedom to adapt the work of the team to meet the needs of the community it serves. The ecclesiastical personnel or church committees will have to assume the rôle of helping the medical team in matters where such help is necessary and meaningful, rather than attempting to administratively control the management of the hospitals. This means that suitable arrangements for a working partnership will have to be established.

2. A New Leadership

It is necessary to indigenise mission hospitals immediately and to give support to the new Indian leadership. Development demands, as we have seen, the community's acceptance of responsibility for its own needs. This will be possible only if foreign missionaries and mission boards relinquish their power to the national board and personnel, and give them power for both policy-making and administration, thereby contributing to a new pattern of partnership. The Indian Church itself has become a part of the Christian institutionalism where the overseas boards hold the reins and exercise authority in general policy-making and even in day-to-day management through their foreign personnel, who seldom have a real understanding of the ferment in the country, nor any informed desire to develop the whole national community. Mission hospitals are also entangled in a similar institutional structure, with much real, often hidden, authority being in the hands of foreign personnel who have been sent to serve on their medical and administrative staffs by the overseas boards and societies which concurrently provide capital and operating funds.

The overseas mission boards are now facing two problems. They are finding it difficult to meet the financial demands from mission hospitals where the expenses have gone up. The situation is complex, because it is also increasingly difficult to get suitable medical personnel from their own churches to go overseas and man the mission hospitals. Even when they find such persons, governmental restrictions often prevent such appointments. Therefore, mission boards are forced to appoint Indian personnel for their mission hospitals. Frequently these Indians have not been given any real authority or responsibility. They are so circumscribed in their sphere of work that they can neither integrate their work with the national goals nor develop the mission hospitals to keep pace with technical advancement. Denominational and other problems have kept them from the creative way of partnership in their endeavour. They often feel that they are only employees of a foreign concern. The few remaining foreigners on the staff, sometimes less qualified than the Indian staff, still retain power and dictate terms, making it impossible to have a cohesive healing team. Further, the economic and living standards of foreign and Indian staff reveal a glaring inequality which leads to unhealthy relationships. It must be recalled that many of the foreign boards are anxious to hand over responsibility to Indian churches, but these churches are not really competent to run the institutions, let alone hospitals and other medical ventures which demand special skills and expertise.

The Indian Church will have to find suitable Indian Christian medical personnel to take over the responsibility for developing its mission hospitals. If there are foreign personnel of any category—doctors, nurses or others—they will have to work as partners or assistants, helping the Indians in the management of the hospitals. It is important for the Indian Church to recognise the fact that the only solution to

the problem of mission hospitals lies in the developing of a new leadership.

It is unrealistic on the part of the Church to expect Christian men and women to dedicate and devote their life to mission hospital work and to take leadership in church work, without providing them adequate financial security. It is unrealistic and unfair to compare their salaries and other benefits with those of other church workers. If comparisons are to be made, they have to be with those of their counterparts elsewhere. If people are satisfied financially, and are given responsibility, encouragement and support, then the problem of personnel will cease to be a problem.

3. Integrated Health Care Programme

Health, as we said earlier, is wholeness, and not just freedom from disease; as such, it has to be considered in the context of an integrated person and in relation to the community. This should be the aim of our medical missions.

This points to the need to get more meaningful involvement in the community. Most of the mission hospitals are patient- and disease-oriented and they serve only those patients who come to the hospital. The love and concern that the medical team can have for these patients is limited to the period of time that they are hospitalised for the illness. Scientifically, much more emphasis is given, today more than ever before, to the family and to the community of the patients, not only on ætiological grounds, but also for a maintenance of positive health. Hence it becomes extremely important for the mission hospitals to get involved in the community.

Considerable emphasis is laid in affluent countries on the hospital being the pivot for all community health services, as it is already the physical and professional centre of the medical world. Yet we have heard it said again and again in recent years that the hospital has outlived its usefulness and must be replaced by some other form of medical service. When considering the special rôle of Christian medical work in India, it is essential to accept that mission hospitals do have a place in the care of the sick, but this place will have to be secondary to its involvement in the community. The community has to be the centre of activities, the hospital supplementing such activities that are essential for the community.

The medical teams in mission hospitals can easily get themselves isolated within the four walls of the hospitals if they are only taking care of the sick that come to the hospital. Medical men who have been trained in disease-oriented and hospital-based medical educational programmes will probably find extreme difficulty in accepting the community-centred activities. It is only natural for them to feel that their sophisticated training is not being properly utilised, when for most of the time they will be dealing with only minor curative work. Government and other agencies are involved in most of the public health measures. It is well to realise that considerable frustrations for medical personnel in community-centred programmes are inevitable; and yet, without such involvement, Christian medical work becomes meaningless.

Family Care Programme

From the contact with the patients who come to the hospital, all members of the medical staff can initiate home-visiting, either individually or as a team. There can be as many medical teams as there are medical personnel in the hospital,

The purpose of these home visits is not just to take care of the sick, which function will only be incidental, but to extend concern and interest on a personal level and to educate the families to take responsibility for their own health. The team could function as general advisers and counsellers, besides helping families in their health problems. The medical teams can thereby show a total concern for the family. Each medical team will have to decide on the number of families to be visited according to the time and facilities available, and co-ordinate its activities with those in the community and the hospital. Periodical visits over the years will have to be planned. Such families can be considered as adopted by the mission hospital for continuing service and study. The medical team will be able to educate the community to recognise its own medical needs and help it to assume responsibility to meet those needs. The team should be able to get consultant services of local scientists, educationists and economists, and thus help the community to understand not only its health needs but its socio-economic and even spiritual needs as well, leading to the total healing of the community.

Family care programmes will have to be an additional activity that the mission hospitals embark on. The hospitals will have to carry on their usual curative activities, because of the importance of curative work and also because it is still the main source of revenue. Because the team members will have to be in the hospital most of the time, and as the earning members of the family will be away at work, the medical team will have to devote two to three hours in the mornings or evenings, twice or thrice a week, for the family care programme. It is no doubt an added responsibility, but this programme will give relevance to Christian medical work.

Utilisation of Governmental and other Facilities

Mission hospitals will have to work in collaboration with nearby institutions, either mission or governmental, to which they can refer cases for specialised services. They must work closely with health services of all regional and national organisations, such as those dealing with tuberculosis, leprosy, malaria and venereal diseases. Mission hospitals must recognise the facilities that can be utilised in primary health centres or bigger hospitals of the Government. They will have to feel that they are part of the community and make use of available facilities in the community, join with other organisations in planning, and work in co-operation with related national institutions.

The importance of proper planning cannot be overemphasised. At the national and governmental level we are committed to planning, both in the private and public sectors. Christian medical work, which is a part of the private sector, obviously will have to relate its strategy of action to the planning of the Government. Institutional isolationism is useful neither to the institutions themselves nor to the people. The Government has accepted the concept of regional health planning; it is setting up large and small hospitals and a great many primary health centres covering regions or blocks. All the 620 mission hospitals have come up without any planning or co-ordination. What the mission hospitals can do now is to plan their activities at the local level, co-operating with local authorities, and taking initiatives to make their programme really effective.

Congregational Participation

Involvement with community can bring about opportunities for the participation of the congregations of the Church in many activities. The congregation, being a part of the

community, can take responsibility for promoting public health measures and the acceptance of developmental plans. Programmes related to health, educational counselling, socio-economic concern, education of children, promotion of responsible parenthood or family planning, etc., cannot be confined to mission hospitals and their medical personnel alone. The family care programme also requires the active participation of the congregation.

Community Participation

Development means not only the recognition of needs, but also meeting these needs by the community. Mission hospitals can enable the community to shoulder this responsibility. Through their 'adopted families' they can promote group action. The group in turn can organise community activities geared to development. It is at this level that planning should be initiated with the local authorities. It will not be difficult to bring about community participation if the mission hospitals and their medical teams can start the family care programme. If hospitals and dispensaries get themselves intimately involved in the community, they will be offering integrated health care, thus aiding the total development of the community.

Utilisation of Existing Facilities of Christian Hospitals

What we have said above provides a different perspective for our thinking regarding the future of mission hospitals. If we accept the proposed changes in our objectives and strategy of action, then we need not be preoccupied with the question of their becoming obsolete or superfluous, or of their being in need of expensive equipment and costly renovation. The existing facilities can be used to greater advantage once the activities of the mission hospitals are changed from hospital-centred to community-oriented. If

the hospitals are to cater to the well-to-do, who constitute less than 10% of the population, obviously some of the mission hospital facilities are outmoded. However, if the purpose of the hospital is to meet the needs of the community, either urban or rural, it can still be utilised for that purpose, and there may be no need to consider the closure of some of them, or to recommend the transfer of their management to the Government.

Quality of Christian Leadership

The key factors in the entire operation of Christian medical work are the quality of personnel and the team spirit of the workers. The importance of the motivation, adaptability, temperament and professional competence of the leader of the medical team cannot be over-emphasised. The success or failure of the hospitals will depend entirely on the availability of such Christian medical leaders. Even more than all the above-mentioned qualities, the personnel of the mission hospitals need a genuine spirit of dedication to serve the Master in the healing ministry of the Church. This applies to every member of the team. It is the responsibility of the Church to develop such Christian leadership in all categories of the health team. It is obvious, therefore, that the mission hospital personnel need more training, not only to acquire professional competence but also in such subjects as community orientation and hospital and community organisation.

Training of Medical and Other Personnel for Medical Team Work

There are three Christian Medical Colleges in India, and one of them trains more than 70% of its students for work in mission hospitals. It is absolutely necessary that such training should be intensified. The medical and nursing courses

are long, tedious and hard, besides being expensive. Often parents find these courses a great financial burden, and they have to borrow, or mortgage their assets, to make it possible for their children to study. They therefore expect their children to help them financially when they graduate. As the students marry and start families of their own, their own financial commitments also increase. The churches must recognise these facts, and realise further that if they help the students financially during their course of study, it will be easier for them to get health personnel for their mission hospitals. The foreign mission boards still have a responsibility and a wider opportunity for service in India. This is to develop leadership among Christian medical workers to whom the charge of medical work has to be handed over. This is possible only by actively supporting the training institutions that aim at producing the health personnel necessary to serve in mission hospitals.

4. A NEW FINANCIAL OUTLOOK

It is important that the churches consider how their hospitals can manage their medical programmes within their meagre resources. They must encourage the hospitals to earn enough income from patients to maintain themselves, that is, to make the hospitals self-supporting. Obviously, hospitals need the income from rich patients. But rich patients can be drawn to a hospital only if certain conditions are satisfied, as for instance the reputation of the staff, effective and efficient service, good and adequate equipment, and physical facilities which are socio-economically acceptable. To maintain such facilities we shall have to incur higher maintenance expenses. This indeed steps up an economic spiral : rich patients—better physical facilities—more technical and maintenance personnel—more expenses—richer

patients. The end result is that the mission hospital becomes a business concern for providing medical service to the affluent, which has little relation to the original objective for which it was brought into existence. Thus the main need at the present time is that of establishing the economic viability of the mission hospitals. This problem is brought about by the following factors :

(i) Medical education has developed into a matter of highly technical specialisation, and deals with limited areas and specific medical problems ;

(ii) Wealthy patients demand the services of specialists ;

(iii) The disparity between the rich and poor is so great that the rich feel money can buy anything, while the poor do not have enough of the bare necessities of life—food, shelter and clothing.

The money-earning power of the doctors in mission hospitals depends upon their training and ability. This must be given due credit when considering the question of financial stability. Each hospital will have to make a realistic account of its expense and income and adjust its work according to the available financial resources. Hospitals where the cost per bed per day is more than the earning capacity of the population they serve are bound to encounter financial difficulty in maintaining themselves.

The greatest difficulty for medical personnel in all mission hospitals is to limit their work in such a way as to give adequate service to many and to accept the fact that increasing sophistication in medical service will lead to increasing maintenance cost. Specialisation in any branch will involve increasing expenditure which outpaces the increases in income. It is a fallacy to think that more and more specialisation will bring more and more money.

Mission hospitals should resist the temptation to become more of a specialised service, with sophisticated physical facilities and treatment, at the cost of financial stability. It is highly desirable to have a realistic appraisal of the financial situation of the mission hospitals by instituting a cost accounting study with a view to stabilising the hospitals financially. It must be understood that scientific medical care does not mean just technological advancement or the diagnosis and treatment of a few diseases. A very large percentage of illnesses can be scientifically treated within the financial capability of most of our communities. The inclusion of Family Health Care Programmes will add to the function of the mission hospitals and enrich their usefulness in the community without substantially increasing the financial burden, as there is no need in this case to add more health personnel or other facilities. The few cases that need advanced investigation and treatment can be referred to institutions that are capable of dealing with such cases.

CONCLUSION

We raised a few questions, relevant to the medical work of the Indian churches, in the first chapter. We also briefly dealt with the factors which led to this situation. Today the answers to these questions have to be found in the context of the revolutionary changes in the social, cultural, economic and national life of the country. An attempt was made to explain these in the second chapter. The Church's mandate to heal was re-examined in the third chapter, and a few suggestions which may promote development have been considered here in the last chapter. The perspective for this 'thinking aloud' was set by the revolutionary trends in India today, the predicaments of

the mission hospitals and the concern expressed in bodies like the World Council of Churches.

The Indian Church should make its whole-hearted contribution to the making of modern India. The nation's health must be the concern of Christians, and what greater opportunity can there be for the Church than to discharge its duty to the nation through the renewal of its healing ministry ?

NOTES

1. *Christian Hospital Directory*, published by the Catholic Hospital Association of India and the Christian Medical Association of India, 1968.
2. *Christian Medical Association Directory*, 1963.
3. *The Future of Christian Medical Work in India*, Report of Bangalore Consultation : 13-17 January 1969, sponsored by Christian Medical Commission, World Council of Churches.
4. Tubingen Consultation—1964 and 1968.
5. Karachi Congress—1931. Nehru, *Glimpses of World History*.
6. Dr. D. E. Smith, *India as a Secular State*, p. 4.
7. Matthew 10 : 40 f ; Mark 9 : 38.
8. *Matthew 18 : 5 ; Luke 10 : 16 ; John 13 : 20.*
9. Mark 1 : 10.
10. John 11.
11. Mark 8 : 22 f ; Mark 10 : 46-53.
12. Mark 1 : 21.
13. *Mark 1 : 30.*
14. Mark 1 : 33.
15. Mark 1 : 40.
16. Mark 7 : 26.
17. John 9 : 5.
18. *Matthew 11 : 20 ; Luke 10 : 13.*
19. Acts 3.
20. Acts 4 : 4.

1. *The Healing Church*, World Council of Churches, Geneva, 1965.
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3. *The Healing Ministry in the Church*, Bernard Martin.